Appendix 3

Sample HCFA 1500 Claim Form-Physician Anesthesia Services

PICA								EALTH IN							PICA	
MEDICARE ME	DICAID CH	AMPUS		CHAMPVA	GRO HEA	OUP NITH PLAN	FEC BLK	A OTHER LUNG	1a. INSUREI	S I.D. N	UMBER			(FOR P	ROGRAM IN ITEM 1)	
(Medicare #) P (M	edicald #) (Spi	onsor's S	SSN)	(VA File #)		ALTH PLAN	(5)	SN) (ID)		<u> 45678</u>						
PATIENT'S NAME (Las		Middle I	Initial)	-	3. PATIENT	SBIRTH DA	\TE	SEX	4. INSURED	SNAME	(Last Na	ame, Firs	t Name.	Middle	Initial)	
Recipient, Im								F X								
PATIENT'S ADDRESS	(No., Street)				6. PATIENT	RELATIONS	SHIP TO	INSURED	7. INSURED	SADDRE	ESS (No	., Street)				
609 Willow					Self	Spouse	Child	Other								
ITY				l l	8. PATIENT	STATUS			CITY						STATE	
Anytown				WI	Single	e Mar	ried	Other								
IP CODE	TELEPHO	NE (Inclu	ide Area C	ode)			_		ZIP CODE			TEL	EPHON	E (INCL	UDE AREA CODE)	
5555 (XXX)XXX-XXXX			X	Employe	Full-1 Stude		Part-Time Student									
OTHER INSURED'S N.	AME (Last Name, Fit	rst Name	, Middle in	itiai)	10. IS PAT	IENT'S CON	DITION	RELATED TO:	11. INSURED	'S POLIC	OY GRO	UP OR F	ECA N	UMBER		
										\mathbf{M}	- 7					
OTHER INSURED'S PO	DLICY OR GROUP I	NUMBER	₹		a. EMPLOY	MENT? (CU	RRENT	OR PREVIOUS)	a. INSURED'	SDATE	OF BIRT	ТН			SEX	
					YES NO				MM DD YY M F							
OTHER INSURED'S D	ATE OF BIRTH	SEX	×		b. AUTO A	CCIDENT?		PLACE (State)	b. EMPLOYE	R'S NAM	E OR S	CHOOL	NAME			
MM DD YY	M	7	F			YES		NO								
EMPLOYER'S NAME O	R SCHOOL NAME				c. OTHER /	ACCIDENT?			c. INSURAN	E PLAN	NAME	OR PRO	GRAM I	NAME		
						YES		NO								
INSURANCE PLAN NA	NSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?						
									YES NO If yes , return to and complete item 9 a-d.							
	READ BACK OF F	ORM BE	FORE CO	MPLETING	& SIGNING	THIS FORM			13. INSUREI	'S OR A	JTHOR	IZED PE	RSON'S	SIGNA	TURE I authorize	
 PATIENT'S OR AUTH to process this claim. 	IORIZED PERSON'S	SIGNA	TURE I au	ithorize the re	elease of an	y medical or o	ther info	rmation necessary	payment services			ts to the I	undersig	ned phy	sician or supplier for	
below.	o .oqooot pajiiloi	0. 9010		510101 1	,				301 VICES I	u	JOIUTT.					
SIGNED					D.	ATE			SIGNED							
	▲ ILLNESS (First	sympto	m) OR	15. IF			ME OR	SIMILAR ILLNESS.								
DATE OF CURRENT:	INJURY (Accid	lent) OR	,	G	IVE FIRST	DATE MM	DD	YY	FROM	N DD	Y	7	TC	MM	DD YY	
NAME OF REFERRIN		' '	SOURCE	17a. I	.D. NUMBE	R OF REFE	RRING F	PHYSICIAN	1	LIZATIO	N DATE	S RELA			NT SERVICES	
						-			FROM	A DD	Y	1	TC	MM	DD YY	
RESERVED FOR LO	CAL USE					-			20. OUTSIDE	LAB?	i			RGES	i i	
									YES		NO	i			1	
. DIAGNOSIS OR NAT	LIBE OF ILLNESS O	Ω INJUE	RY (BELA	TE ITEMS 1	23 OR 4 TO) ITEM 24F I	RY LINE		22. MEDICAI			ON			1	
	01.2 01 122.1200 0		(.,			· 🗼	CODE			ORIC	3INAL F	REF. NO.		
575.1				3.	L	_		•	23. PRIOR A	ITHORIZ	ZATION	NUMBE	R			
1. A		В	ГСТ	4.	<u> </u>			Е	F	-	G	Тн	T T		К	
DATE(S) OF S	SERVICE.	Place	Type F			ES, OR SUF		DIAGNOSIS			DAYS	EPSDT	<u> </u>		RESERVED FOR	
	MM DD YY	of Service	of Service	(Explair CPT/HCPCS	i Unusual C S I MC	ircumstances	5)	CODE	\$ CHAR	GES	OR UNITS	Family Flan	EMG	COB	LOCAL USE	
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FEDERAL TAX I.D. N	IMPED CON	EIN	1	ATIENT'S AC	COLINIT AN	107		T ACCIONMENTS	28. TOTAL C	LIADOF	1	20. 4142	LINES		30. BALANCE DUE	
IL LEDERAL TAX I.D. N	UMBER SSN	C01		234JEI		· [2/.		T ASSIGNMENT? . claims, see back)	1 1	HARGE XXIX		29. AMO	UNIPA	เบ	VXX VX	
							YES	NO NO	Ψ	i_		\$	10.1		<u> </u>	
 SIGNATURE OF PHY INCLUDING DEGREE 	S OR CREDENTIAL	_S				F FACILITY V home or offic		SERVICES WERE	& PHONE	#		2 RILLIN	NG NAM	⊫, ADDI	RESS, ZIP CODE	
(I certify that the state apply to this bill and a	ments on the reverse	9		,					I.M	l. Billi	ing					
apply to this bill aild a	o made a part mere								1 W	. Wil	lliam	ıs				
.M. Authorize	MM/DD/V	\mathbf{v}								ytown			55	876	54321	
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